

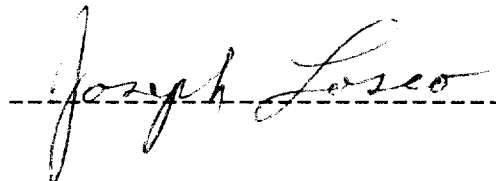
A Note on Fetal Alcohol Syndrome:
Fetal Rights And Maternal Conflicts

An Honors Thesis (HONRS 499)

by

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ABSTRACT

What degree of protection from potentially damaging maternal behavior should be awarded to an unborn fetus? This thesis examines the fetal environment as different conceptualizations of maternal responsibility. Focusing particularly on fetal alcohol syndrome (FAS) as a case study to examine existing legal precedents, it demonstrates how recent knowledge of the fetal environment contributes to the understanding of these decisions. More specifically, it analyzes the contributions of research on maternal responsibility and fetal rights to understand the dynamics of implementing fetal protection policy. Finally, this discussion illuminates theoretical issues regarding the nature of the relationship between individual rights, social responsibility, and legal regulation.

The rising controversy over fetal rights versus maternal rights has been unnecessarily limited to a debate on the moral legitimacy of abortion. This hides the more general discussion of legal and medical obligations to the unborn fetus because abortion, despite its popularity in the literature, represents only a small part of many complex medical avenues by which a maldeveloped fetus can be treated. Indeed, most recent fetal abuse lawsuits do not neatly fit in the right to life framework. It would make more sense if attention were focused instead on medical evidence, legal precedent and legislative policy which is likely to color the treatment of the other issues at hand.

The concept of fetal rights as well as the dynamics surrounding its promotion are practical examples of issues raised by research in the current biological and medical sciences. The intent of this paper is to demonstrate that biomedical knowledge contributes significantly to the understanding of this major policy issue, and in turn, to show how that policy issue stimulates theoretical developments regarding the relationship between individual rights, social responsibility, and even legal regulation.

The first part of this thesis reviews general knowledge about the fetal environment, and it identifies maternal consumption of alcohol as one among a number of threats to healthy fetal development. The second section examines the effect of maternal consumption of alcohol on the unborn, focusing particularly on the critical early stages of pregnancy. The third part casts fetal rights and maternal rights issues in

terms of different conceptualizations of justice. The paper concludes with a discussion of prevention as a policy alternative to what already exists in legislation and legal precedent.

A recent and rapid expansion in knowledge regarding the environment of the fetus has been accompanied by a reemergence of concern for the rights of the fetus to have as safe as possible a sanctuary in the womb. This, in turn, has led to questions regarding the mother's obligations to provide such an environment for the fetus. The assertion of maternal control over her body is being challenged by significant evidence that particular behavior of the mother's activities during pregnancy might endanger the life or health of the fetus. For Patricia King this "increasing awareness that a mother's activities during pregnancy may affect the health of the offspring creates pressing policy issues that raise possible conflicts among fetuses, mothers and researchers"(92). Although the scientific data are new, the idea that a pregnant mother intuitively takes on an obligation to provide a proper environment for the developing fetus is certainly not of recent origin. Plutarch for instance, stated "one drunkard begets another"; and Aristotle: "foolish, drunken or hare-brain women, most part bring forth children like unto themselves, morosos et languidos"(Blank, Life, 63).

To what extent should society take an active role to ensure a proper fetal environment? Aristotle proposed strict state control over breeding and the conditions of pregnancy to back up his concern for the new generation of citizens(Blank, Life, 63). Given the traditional emphasis on prenatal privacy in

reproductive matters, the American legislatures and courts have avoided this dilemma to date by refusing generally to intervene. The landmark Roe vs. Wade, therefore, offered no guidance whatsoever for resolving conflicts of interests where a mother's treatment of her own body might cause harm to the unborn child. However, many woman have been indicted for child abuse for giving birth to children addicted to drugs(Chambers, A1). More such rulings are expected as the precision of knowledge of fetal environmental damage increases. Also, torts for wrongful life might presumably include action against a mother for damage negligently inflicted upon the fetus while in utero.

Recent innovations and refinements in biomedical research and data collection have produced growing evidence of the deleterious effects of the immediate environment of the fetus on its development. The behavioral patterns of the mother during gestation and in some instances prior to conception have been linked to a variety of congenital disorders ranging from reduced IQ and impaired motor coordination to mental retardation, high risk of premature births, and in some cases physical deformation or prenatal death(Ericson, 45). Although the causal nature of these environmental factors in many cases remains tentative and inconclusive the evidence of fetal damage resulting from the behavior of the mother is mounting.

During the first eight weeks of gestation, the cells of the embryo develop into tissues and organs. This process can be interepted by a variety of agents. It is not known precisely to what extent congenital malformations (teratogenesis) are

due to (1) genetic damage, (2) tissue injury in the developing embryo, (3) a combination of these two factors, or (4) environment interaction manifested only in those persons genetically susceptible, but evidence of the teratogenic effects of a variety of drugs is growing(Ericson, 47). While thalidomide is the most conclusive and obvious example, other drugs, including the widely prescribed Valium, are suspected. Nonmedical drugs such as caffeine, nicotine, and marijuana are also suspected, although causal evidence is limited in most cases. In other cases, however, such as alcohol consumption, the data are more conclusive. Also, studies indicate that many of the more than half million chemicals that now abound in our environment, as well as direct radiation from x-rays and other sources, cause chromosomal damage. LSD, cyclamates, methyl mercury, benzene, and vinyl chloride exposure, among others, have been linked to human chromosomal aberrations(Ericson, 47).

There is a risk that any drug ingested by a pregnant woman will cross the placenta and enter the bloodstream of the vulnerable fetus. The belief that the placenta is a barrier protecting the fetus from chemicals in the mother's blood was tragically disproved in the early 1960s by the occurrence in many countries of children born with limbs missing or arrested in development after their mothers took the sedative thalidomide(Blank, Redefining, 132). In 1955, an outbreak of congenital cerebral palsy in Japan was found to be due to the eating by pregnant women of fish contaminated with the industrial chemical methylmercury. Lead chloroform are two other industrial

pollutants that cause birth defects by affecting sex cells; more are under investigation(Blank, Redefining, 132). Even if the mother has built up immunities to particular drugs, the fetus does not have similar protection. The fetus appears especially susceptible to danger early in gestation when it "is a rapidly proliferating and highly differentiating organism, constantly changing in size, cell type, percentage of cells in mitosis, length of cell cycle, dependence on the maternal organism, and ability to replace dead cells"(Blank, Redefining, 133).

Approximately one in ten births defects is the result of an external agent, such as infection, radiation, mutagenic chemicals, or diabetes in the mother(Bayer, 15). For example, the most widely known infection to affect the fetus is rubella, or German measles. Many women who contract this disease in the first three months of pregnancy bear children who have abnormal sight or hearing or are mentally handicapped. Vaccination of girls during childhood or adolescence can prevent this infection. Venereal diseases in the mother can also damage the fetus. The effects of radiation were demonstrated by the increased incidence of birth defects in the offspring of pregnant Japanese women who were exposed to the atomic bomb and of American women who underwent radiation therapy while pregnant(Bayer, 15).

In order to focus attention on that environmental factor which is largely controllable by the mother, the discussion -here focuses on maternal behavioral habits that have been linked

to fetal alcohol syndrome.

Although concern over the adverse effects of maternal alcohol consumption on the developing fetus can be traced back to ancient precedents, it was not until 1973 that researchers were able to delineate a recognizable pattern of fetal abnormalities associated with chronic maternal alcoholism(Warner, 1396). Extensive animal experiments and scores of affected children reported on left little doubt of the reality and origin of this disorder. The fetal alcohol syndrome, here after referred to as FAS, has since received considerable attention and effort now is being directed at better understanding the sources of variability in the effect of alcohol consumption and timing on the fetus. Based on a survey of recent literature, FAS appears to be the most frequent known teratogenic cause of mental deficiency in the western world. Chernoff notes that findings about FAS are especially significant because of the magnitude of alcohol abuse in the western world and they have, therefore, motivated these further research efforts(Blank, Redefining, 173).

According to Clarren and Smith malformation patterns of FAS can be placed in four major groups: (1) distinctive facial features, (2) central nervous system dysfunction, (3) growth retardation, and (4) associated physical abnormalities(Clarren, Recognition, 2436). According to Jones 43 percent of infants born to chronic alcoholics might have significant structural malformations(999). Mental retardation has been one of the most common and serious problems associated with ethanol

teratogenicity. Chernoff notes that FAS is the third most commonly recognized cause of mental retardation, exceeded only by Downs syndrome and neural tube defects(Blank, Redefining, 173). There is a rather typical facial appearance in persons with the fetal alcohol syndrome. Although many disorders feature mental deficiency and structural malformation, it is the facial similarities among children with the syndrome that unite them into a discernible entity.

In addition to the striking facial appearance of FAS children, growth deficiency, both gestationally and postnatally, is common, resulting in a "failure to thrive"(Enloe, 12). Most infants with the fetal alcohol syndrome are growth deficient at birth for both length and weight. Growth in head circumference is below normal and mental retardation, ranging from minor deficiencies to severe retardation is heightened(Clarren, Brain, 65). Neurologic abnormalities may be present from birth in affected children, again reflecting the prenatal nature of this condition. Poor coordination, hyperactive behavior, and tremors are also commonly reported in FAS babies. Hyperactivity is also a frequent component of the FAS in young children(Barrison, 16). It should be noted, however, that not all of the offspring even of chronic alcoholics display these problems. Also, there are numerous instances of children born with only partial manifestations of FAS, especially to mothers who drink at lesser levels.

Although progeny of chronic alcoholics are at highest risk to manifest extreme FAS characteristics, considerably lesser

maternal alcoholic intake is also linked to a variety of fetal problems. For instance, a major human study found that 43 percent of the offspring of chronic alcoholic women have features of FAS(Brody, A1). However, consumption of as little as one ounce of absolute alcohol per day results in 11 percent of the offspring exhibiting FAS features. At consumption levels above two ounces this increased to 19 percent(Brody, A1). Because these latter two categories represent a substantially larger proportion of the population than the chronic alcoholics, prevention of FAS requires considerably more understanding of the effect of these lower consumption levels on the fetus.

In response to these data, the Food and Drug Administration in 1977 announced that while six drinks per day is sufficient cause to establish a major risk to the fetus, as little as two drinks per day could increase the risk of abnormal fetal growth and performance(Hanson, Effects, 32). According to Hanson, no safe level of maternal alcohol intake during pregnancy has been established(Hanson, Reproductive, 67). Until it is, an overwhelming number of experts are recommending that women abstain from alcohol during pregnancy. Not surprisingly, alcoholic beverages now carry the following warning, "According to the surgeon general, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects"(U.S.Dept., Surgeon, 1).

There is a complicating factor, however, concerning maternal alcohol consumption. Crucial but yet preliminary evidence relates to the timing of exposure to alcohol. In their study

of the effect found that the consumption level in the first month of pregnancy was a better predictor of fetal outcomes than amounts consumed later in the pregnancy.

This result is not unexpected as a knowledge of embryology would predict that in order to produce major abnormalities of morphogenesis, prenatal insults to development must occur relatively early(Cooper, 225).

Despite this evidence, however, it should not be assumed that alcohol consumption during the later stages of pregnancy is safe. Brain growth as well as the growth of other organ systems proceeds throughout pregnancy and might be effected by maternal alcohol consumption late into the pregnancy.

The data that point to the critical early stages as the danger period for major central nervous system malformations caused by maternal alcohol abuse, however, are devastating for efforts at preventing FAS, since they imply that FAS is far along before most women are even aware of their pregnancy. By the time the women knows she is pregnant, damage may have already taken place and it is already too late to avert the most severe malformations. This means that "even with full knowledge of the syndrome, some women not contemplating pregnancy will conceive and expose their developing embryo to high blood alcohol levels during critical stages of development"(Clarren, Facial, 665).

What is required, therefore, for the prevention of FAS is to "have all women of childbearing age who are not practicing contraception modify their drinking habits to be compatible with normal prenatal development"(Little, 254). Obviously,

this is an unlikely possibility in western society even if considerably more funds are spent on public education efforts. Given the aggregation of evidence demonstrating the deleterious effect of alcohol consumption on fetal development, however, it is certain that significantly greater attention will be directed toward the responsibility of the mother to provide an alcohol-free environment for her developing fetus. But consideration of preventive actions must be delayed. We must now turn our attention to the political rights of the fetus if we are to understand the larger issues at hand.

Initially, then, it is necessary to understand how the legal system conceptualizes the fetus if we are to understand how it treats FAS affected babies. Although our legal system historically has treated the fetus as part of the woman bearing it and has afforded it no rights as an entity separate from her, with the exceptions necessary to protect the interests of born individuals, recently, without any fundamental revision of Roe, fetuses have been granted rights based on the view that the fetus has interests that are potentially hostile to the pregnant woman's (Sabatini, 1996). The scope of these rights is evolving. For example, most states, now consider fetuses that have died in utero to be "persons" (Blank, Biomedical, 66).

Growth in fetal rights, even in the context of women's privacy right to abortion, may constrain what women may agree to and what researchers may do in the area of fetal research. The most dramatic reformulation of fetal research policy, however, might have followed the Supreme Court ruling in Webster

vs. Reproductive Health Services(Blank, Biomedical, 65). Among other issues, was the Missouri law's preamble, declaring that it is state policy that "the life of each human being begins at conception," and defines the conceptus, and thereby embryo and fetus, as a person in terms of the Constitution(Blank, Biomedical, 66). In this instance, the Court did not decide on the issue, but the selection of such a case indicates that a decision may not be too distant. We can speculate that if a positive decision had been rendered an emphasis on research remedying fetal defects would become more pressing.

This emphasis on fetal defects raises questions concerning prenatal diagnosis and selective abortion of those fetuses affected with FAS. The "right to be born healthy," say Murphy, Chase, and Rodriguez, is misleading because it actually means that "only healthy persons have a right to be born"(Murphy, 81). To Alexander Capron, the recognition of an enforceable right to be born with a sound, normal mind and body would "open the door to judicially mediated intervention of limitless dimensions"(124). For many of those affected, the choice is not between a healthy and unhealthy existence, but rather between an unhealthy existence and none at all. Thus it is evident that the legal protection afforded to a new born may be invalid for many FAS affected fetuses.

The concepts of rights and responsibilities are, of course, closely intertwined for both the fetus and the mother. The responsibility to affected persons can relate either to those presently living with the FAS or potential persons who would

be affected if they are born. It seems that the responsibility toward those already living is to protect their well-being and to provide all possible means of minimizing their problems(Annas, 16). The responsibility toward the yet unborn persons is much less clear and fraught with dilemma. Certainly, there is a societal responsibility to reduce the probability of any one individual being affected by FAS. Does this mean, however, that coercive measures should be employed when voluntary compliance to proper prenatal behavior fails? Perhaps the most foreboding aspect of allowing increased state involvement in pregnant women's lives in the name of the fetus is that the state may impose direct injunctive regulation of women's activities. For many, "the notion of sanctions during pregnancy is an unjustified limitation on personal liberty"(Robertson, 27).

Responsibility to affected persons becomes even more ambivalent when discussing screening of women at greater risk of producing a FAS child. Implicit in such an argument would be the sacrifice that might result if the women at greatest risk were not allowed to reproduce. In other words, once one focuses on potential affected persons, a dilemma arises in that probability dictates that any action taken to eliminate the "at risk women" will affect a larger number of potentially healthy than unhealthy children(Blank, Biological, 170). On this basis alone, without taking into consideration the rights of the women, compulsory screening of at risk women and its logical extension of prohibiting procreation in such instances

would be illogical on public health grounds(Blank, Biological, 171). Obviously, this does not preclude the screening of potentially at risk women on voluntary grounds or even the justification of mandatory screening on some broader responsibility. In fact, Robertson and Schulman note that "legal requirements for a registry and counseling would not be an unethical intrusion on privacy"(26).

The recognition that government regulation of maternal/fetal regulations infringes upon maternal privacy rights represents only one side of the constitutional balance. Under strict scrutiny, courts must also determine whether and when the state interests that lie on the other side become compelling(Sabatini, 1003). Among the broad state interests that could be offered to justify criminal fetal abuse statutes are the protection of fetuses from the risk of miscarriage or still birth and the protection of fetuses from the risk of birth defects caused by prenatal injury(Sabatini, 1004). These state interests could be legitimate either as an outgrowth of the state's power to protect potential life, discussed in Roe, or as an extension of its ability to protect born persons. The fact that a born child may suffer as a result of fetal abuse adds to the state's interest. As a logical matter, the strength of the state interest in preventing any particular maternal activity depends on the likelihood that the activity will lead to harm and the significance of such harm to the fetus or the born child.

Since the Roe decision, the law increasingly has recognized the fetus in contexts that are not contingent upon subsequent

live birth. The creation of fetal rights not contingent upon subsequent live birth reflects a legitimate desire to protect the rights of the pregnant woman and the expectant father. Recognizing fetuses in wrongful death actions serves to compensate parents for the loss of their expected child and to protect the interests of a woman who has chosen to carry her pregnancy to term. Such recognition also seeks to deter and punish the tortious conduct. Similarly, feticide laws use the criminal law to protect pregnant women from physical attack and from the harm of having their pregnancies involuntarily and violently terminated by third parties responsible for the negligent or criminal destruction of fetuses is therefore consistent with, and even enhances, the protection of pregnant women's interests.

Yet the form that this legal recognition often takes creates the potential for the future expansion of fetal rights in ways that conflict with women's interests. By sometimes identifying the fetus rather than the woman as the locus of the right when there is no live birth, recent laws have reflected a more expansive view for FAS affected babies. The law no longer recognizes the fetus only in those cases where it is necessary to protect the interests of the subsequently born child and her or his parents. Rather, the law has conferred rights upon the fetus itself. Conceptualizing the fetus as an entity with legal rights independent of the pregnant woman has made possible the future creation of fetal rights that could be used against the pregnant woman who abuses alcohol during early gestation.

In Grodin v. Grodin, a Michigan court held that a child could sue his mother for taking tetracycline during her pregnancy, allegedly resulting in the discoloration of the child's teeth. The court stated that the appropriate standard for liability was that of the "reasonable" pregnant woman(Johnsen, 604). Another court hearing, Curlender v. Bio-Science Laboratories, has suggested that a woman may be sued by her child for not preventing its birth if she had prior knowledge of the probability of its being born "defective"(Johnsen, 604). In some states, a woman can be deprived of custody of her child even before its birth if the state feels that her actions during pregnancy endanger the fetus. In Michigan, a state whose laws do not expressly extend to "prenatal abuse," a court held that evidence of a woman's "prenatal abuse," a court held that evidence of a woman's prenatal "abuse" or "neglect" could be considered during proceedings instituted by the state to deprive her of custody of her newborn child. California's criminal child abuse statute, which requires a parent "to furnish necessary food, clothing, shelter or medical attendance," extends to fetuses and imposes a criminal penalty of up to one year in jail and a two thousand dollar fine(Johnsen, 605).

The conclusions one can draw from the disparate legal treatment of fetuses are limited. To some extent, through live-birth and viability requirements and nonenforcement of criminal statutes, states have evinced a lesser interest in protecting fetuses from harm than they have in protecting the born. Thus

the treatment of fetal injuries in other areas of law provides some support for the proposition that a state's interest in preventing fetal abuse is less compelling than its interest in protecting a child from post-natal harm. It is difficult to say more, however, because current law primarily addresses harms that nonmaterial third parties inflict, which are easily distinguishable in constitutional terms from maternally inflicted harms. However, the state's interest may be trumped by a privacy right when maternal conduct is in question. In short, other areas of the law provide little guidance, and there is some leeway in the weight that a state may assign to fetal interests.

In addition to consideration of the rights of affected persons, society must provide parents or prospective parents with adequate information upon which to make informed decisions. At some point, consensus must define if and when responsibility to the affected persons takes precedence over the rights of the parents to have or not to have children. This question without doubt is a difficult and sensitive one, and any determination of the boundary between maternal rights and responsibility and concern for the affected person is bound to be controversial. Consequently, it is doubtful that any solution will be forthcoming. The extent to which society is bound to overrule the right to procreate in order to protect those affected or potentially affected by FAS, however, will be an evermore crucial question as more is understood about the variables of volume of alcohol consumption and timing on the fetus(Feinberg, 132). Obviously, the rights of the mothers

and those of their affected offspring will not always be at odds. Given the pluralistic value system in the United States, however, conflict is bound to be common, nevertheless.

In addition to the duty of society to minimize its interference in the decisions of individuals to reproduce as they desire there are other concerns relating to responsibility towards individual citizens. Opposition to selective abortion on moral or religious grounds is intense and sincere and cannot be ignored as a central aspect in establishing any "at risk" intervention programs. Since most prenatal diagnosis techniques and goals center on therapeutic abortion as an alternative to carrying a diagnosed defective fetus to term, amniocentesis has become a target of those groups concerned with the right to life(Feinberg, 133). Any societal decision must take account of these moral dilemmas raised by intervention in the life process.

Additional areas of concern relate to individual perogatives to privacy in the procreative process. Criticisms of amniocentesis as an invasion of privacy are strongly held by many, despite a general societal acceptance of the objectives of that technique(Murphy, 109). Questions relating to stigmatization of couples who choose to have children despite the high risk for their offspring and those who reject prenatal diagnosis or therapeutic abortion as alternatives must also be examined. Responsibility to parents as citizens with certain childbearing freedoms must be emphasized, although it cannot be the only consideration in any policy decision.

Statutes designed to prevent fetal harm could affect a wide range of personal decisions. Almost any decision that a pregnant woman makes with respect to her own body, in this instance drinking, may injure a fetus and thus take on legal significance if fetal abuse is criminalized. Regulation of such activities implicates the right to privacy in reproductive decision making first articulated in Griswold v. Connecticut (Sabatini, 1999). The Griswold Court, in striking down a Connecticut law that prohibited married couples from using contraceptive devices, recognized that certain intimate decisions deserve constitutional protection. Later cases built on Griswold to reinforce an understanding of this privacy right as the right to make decisions within the familial and procreative spheres, free from state interference.

This right of the individual to control procreative and familial decisions should also apply to the maternal decisions potentially infringed upon by fetal abuse legislation. The decisions in question here -- when not to drink, when to go to the doctor, whether to have sex, and so forth -- have both procreative and nonprocreative aspects. Indeed, regulating such decisions for all people -- for example, banning all alcohol consumption -- has no procreative significance. If states limit consumption only for pregnant women, however, they would be regulating the procreative aspect of the decision whether to drink. Such laws seek to control the incidents of procreation, infringing on a woman's power to make decisions about how she will live her life during her pregnancy.

Broad fetal abuse statutes that are patterned on child abuse statutes -- those that make neglecting or abusing a fetus a crime without specifying what constitutes neglect or abuse -- may be constitutional for two reasons. First, such statutes would be void for vagueness because they do not define the specific forms of abuse that constitute crimes and thus would not give notice to mothers of the scope of their duties toward their fetuses (Johnsen, 606). Second, such statutes could be interpreted to require a degree of infringement on maternal rights not justified by the extent of fetal protection they offer; thus they would not be narrowly tailored enough to survive statute that included fetuses could be interpreted to punish the taking of drugs that are essential to the mother's health but harmful to the fetus. This result stands in opposition to the standard articulated in the abortion cases -- that concerns for maternal health constitutionally outweigh concerns for fetal health throughout pregnancy.

When applied to narrower statutes targeted at specific conduct, strict scrutiny yields less obvious results. Statutes banning specific types of conduct by pregnant women would not fail for vagueness as would the broad statutes discussed above. Under a strict scrutiny standard, the state has the burden of establishing that the banned maternal activity bears a clear relation to significant fetal harm and that banning the activity is not an over-encompassing means of protecting the fetus from that harm (Johnsen, 613). The following factors should bear on how much weight courts should assign to both the maternal

and state interests. First, because the rights of both procreative privacy and bodily integrity are justified by reference to tradition, the maternal right to decide should be given more weight when the decision is one traditionally accorded to the individual. Second, as discussed above, the state's interest becomes stronger as the likelihood increases that the banned activity will lead to harm and as the harm becomes more significant(Johnsen, 614).

Gustafson argues that the "major persisting matter of moral choice is whether preference should be given to the individual or the community"(529). There are many ways in which this tension between individuals and society can be stated. One can talk about rights of the individual v. costs or benefits to the community; or the rights of the human race to survive v. the rights of a mother to bear a defective child. Whatever the distinction, most resolutions of fetal abuse dilemmas center on this conflict between the mothers reproductive rights and the fetuses right to be born healthy. Rights of individuals must be weighed against the rights of society. Callahan sees little chance of a happy balance and contends that all solutions are bound to be only temporary(265).

Fletcher sees the conflict reduced basically to a sanctity-of-life v. a quality-of-life ethics, and he opts for the latter. His "situational ethics" places emphasis directly on the principle of proportionate good(75). He contends that one must attempt to compute the gains and loses which would follow from several possible courses of action (or nonaction) and then choose

the one which offers the most good. The common welfare has to be safeguarded by compulsory control if necessary, according to Fletcher: "Ideally it is better to do the moral thing freely, but sometimes it is more compassionate to force it to be done than to sacrifice the well-being of the many to the egocentric rights of the few"(76). Fletcher favors compulsory controls on reproduction if they are needed to promote the greatest good for the largest number.

Taking an opposing position, Beecher argues that society exists to serve man and not vice versa(249). Therefore, individuals have certain inalienable rights which cannot be taken from them by the state. Paul Ramsey contends that "parenthood is certainly one of those 'courses of action' natural to man, which cannot without violation be dissembled and put together again..."(109). The threat to the autonomy of the pregnant woman would therefore outweigh any state regulation. Indeed, this position would consider reproductive rights to be inalienable and beyond state authority.

Through a long series of rulings, the courts have consistently interpreted the right to life as including an inherent claim of citizens to health care and to a free choice in making health decisions. When rights and the common good conflict, the individual's claims to health care generally has taken precedence. Within the context of expanded technological possibilities and the accompanying costs, attention now has shifted to determining what, if any, limits should be placed on claims upon society by individuals for health care(Little,

257).

Americans' preference for curative over preventive medicine has been well documented. This orientation is reinforced by the emphasis on the technological fix, the hesitancy to interfere with individual lifestyle choice, and the powerful momentum of the medical research community(Blank, Life, 137). Moreover, the medical profession has pursued the search for cures to disease more vigorously than ways to prevent disease. Often, however, the advanced technologies it develops are supportive rather than curative; that is, instead of curing a disease, they preserve a particular level of personal health by creating a continual dependence on further medical treatment. Evidence suggests that the most significant improvements in health have come from preventive, not curative or supportive, medicine even though these latter efforts are the most dramatic and, therefore, most easily funded(U.S.Dept., Health, 28). Most advances in preventive area, in turn, have come from areas outside medicine, primarily in improved sanitation, nutrition, housing, and education.

Although many proposed preventive efforts may not be cost-effective, when well planned and executed preventive medicine can provide a high return on its investment. Conversely, curative medicine is often of questionable utility, particularly near the end of the life cycle(U.S.Dept., Health, 29). Here again, though, society's obsession with prolonging life forces us to invest huge amounts of scarce health dollars in a quest to extend life even if only for a short time. Moreover, often

the life we are saving is of low quality, spent attached to various tubes and machines in a sanitized hospital setting. The recent growth of hospice care and the frequent refusal of these heroic lifesaving measures represent a repudiation of the high-technology extensions of life that have become a major aspect of our "health" care system(Little, 266).

The most difficult policy alternative for the prevention of FAS affected children is preventive behavior. Attempts by the government to intervene in lifestyle decisions are inherently controversial. For instance, laws requiring motorcyclists to wear safety helmets have been attacked as paternalistic, unwarranted governmental interference in behavior that does not threaten the health of others(Blank, Life, 138). Many lifestyle mandates have been either rejected by the courts as violations of individual autonomy or rescinded by legislatures under constituency pressure. Nevertheless, pressures emerging from the coming health-care crisis demand that we consider much more closely (1) the role individuals play in contributing to their offsprings health problems, (2) a shift of responsibility for health toward the individual, and (3) a renewed emphasis on individuals' obligations to society to do those things that maximize health(Little, 267).

Although I hesitate to state that FAS has any positive aspects, it does provide several crucial lessons that might ultimately help design a more rational health policy. First, because no technological fix has been forthcoming, FAS clearly shifts emphasis to a preventive strategy. More than any other

disorder, it demonstrates how intimately individual behavior is related to health. It also illuminates how changes in behavior can substantially reduce the existence of such an unnecessary affliction.

This thesis began by pointing out the somewhat susceptible nature of the fetal environment. It is because of this susceptibility that the concern for fetuses has grown in the last twenty years, through new biomedical research and through decisions of the courts invigorating both statutes and the constitution. But susceptibility is not a one-way proposition. We can perceive, that society's interest in protecting the fetal environment from the harmful effects of alcohol may conflict with a mother's civil liberties. Clearly, a woman's right to bodily autonomy in matters concerning reproduction is protected by the constitutional guarantees of liberty and privacy. Society should assume a prenatal role in protecting those fetuses that come to term. In this regard, voluntary compliance to proper prenatal behavior represents the superior route to harmonize each parties interests'.

In conclusion, we are compelled to ask, Are objections to fetal protection based on technical, medical, or political grounds? This question is the most critical one for determining fetal protection policy in the 1990s as well as for sorting out theoretical relationships. If fetal protection is solely a technical issue, then creation of some sort of bias-free statutes should quiet the debate and produce some consensus on perceptions of justice. If it is a combination of technical,

medical, and political issues, the debate will probably rage on, with each side invoking justice rhetoric as a powerful tool to gain support. Because no definitive tests or absolute standards exist, the ultimate definition of fairness in fetal abuse policy depends upon consensus between the biomedical research and the congressional-judicial communities.

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